Appeals: eligibility and health plan decisions in the Health Insurance Marketplace

There are two kinds of appeals you can make once you have applied and enrolled through the Health Insurance Marketplace:

- After you have applied for coverage in the Marketplace, you'll get an eligibility notice that explains what you qualify for. If you don't agree with that notice, you may be able to file an appeal.
- Decisions from the health plan that you chose through the Marketplace. For example, if your health insurer refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed by a third party.

  Tip: No matter what kind of appeal you make, keep copies of all information related to it. This includes paperwork, notes from phone calls, and any other documentation that is sent to you or that you send to the Marketplace or the insurance company.

Appealing eligibility decisions

What Marketplace decisions can I appeal?

- Whether you're eligible to buy a Marketplace plan
- Whether you can enroll in a Marketplace plan outside the regular open enrollment period
- Whether you're eligible for lower costs based on your income
- The amount of savings you're eligible for
- Whether you're eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Whether you have to pay a fee because you don't have insurance (this is called being exempt from the individual responsibility requirement, if you filed an exemption request)

How do I file a Marketplace appeal?

There are 4 ways to file a Marketplace appeal.

1. Log into your "My Account" at **HealthCare.gov/marketplace/individual** (find the icon at the top right of the screen)
2. Call **1-800-318-2596**. (TTY: **1-855-889-4325**.)
3. Mail in an appeal request form. These forms will be available soon.
4. Write a letter to:
   Health Insurance Marketplace
   465 Industrial Blvd.
   London, KY 40750-0061

After you file an appeal, you'll get the following in the mail:

- A letter that states that your appeal was received.
- A letter asking for more information or documentation if needed.
- Our response, which we must mail within 90 days of when we received your appeal request.

You can also appoint an authorized representative to help you. Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you. If you want to appoint a representative, you can do so one of two ways:

1. Complete an "Appointment of Representative" form. Visit **HealthCare.gov** to get this form.
2. Submit a written request with your appeal. Be sure to include:
   - Your name, address, and phone number
   - Your (case/record/request/file) number
   - A statement appointing someone as your representative
   - The name, address, and phone number of your representative
   - The professional status of your representative or their relationship to you
   - A statement authorizing the release of your personal and identifiable information to your representative
   - A statement explaining why you're being represented
   - Your representative's signature and the date they signed the request

For information on how to get help with the appeals process see the section titled ***"Getting help with appeals"*** on page 4.

Appealing a health plan decision

If your health insurer ends your coverage or refuses to pay a claim that you filed, you have the right to appeal the decision and have it reviewed by a third party.

Your insurer must notify you in writing and explain why you were denied within a set amount of time (based on the type of claim you filed). And they have to let you know how you can dispute their decisions.

Steps of the appeals process:

1. After your health insurer denies your claim or ends your coverage, you can begin the appeals process. Any instructions specific to your health insurer will be listed on the information they sent you when they denied your claim.
2. An **internal appeal** is the first action you can take, and must be filed within 180 days (6 months) of receiving notice that your claim was denied. To file an internal appeal you must:
   - Complete all forms required by your health insurer or write to your insurer with your name, claim number, and health insurance ID number.
   - Submit any additional information that you want the insurer to consider, such as a letter from the doctor.
3. At the end of the internal appeals process, your insurance company must provide you with a written decision. If your insurance company still denies you the service or payment for a service, you can ask for an external review. The insurance company's final determination must tell you how to ask for an external review.

An **external review** is the final step in the appeals process.

- Typically, you must file a written request for an external review within 60 days of the date your insurer sent you a final decision. The notice sent to you by your health insurance issuer or health plan should tell you the timeframe in which you must make your request.
- You may appoint a representative (like your doctor or another medical professional) who knows about your medical condition to file an **external review** on your behalf.
- The information on your Explanation of Benefits (EOB) or on the final denial of the internal appeal by your health plan will give you the contact information for the organization that will handle your external review.
- The external reviewer will issue a final decision. An external review either upholds your insurer's decision or decides in your favor. **Your insurer is required by law to accept the external reviewer's decision.** Standard external reviews are decided as soon as possible – no later than 60 days after the request was received.

Insurance companies in all states must participate in an external review process that meets the consumer protection standards of the health care law. Your state may have an external review process that meets or goes beyond these standards. If so, insurance companies in your state will follow your state's external review processes. If your state doesn't have an external review process that meets the minimum consumer protection standards, the federal government's Department of Health and Human Services (HHS) will oversee an external review process for health insurance companies in your state.

> **Note:** You can file your internal appeal and external review at the same time, or file an expedited appeal, if the timeline for the standard appeal process would seriously jeopardize your life or your ability to regain maximum function. A final decision about your appeal must come as quickly as your medical condition requires.

Getting help with your appeal

Whether you're appealing an eligibility decision or a health plan decision, you don't have to do it alone. There are many resources available to help you with your appeal.

- You can call the Health Insurance Marketplace Call Center at **1-800-318-2596** (TTY: **1-855-889-4325**) 24 hours a day, 7 days a week. Or visit **HealthCare.gov** to get more information about appeals.
- Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help you, along with other local organizations. Visit **LocalHelp.HealthCare.gov** to find help in your area.
- You have the right to get help and information about appeals and other Marketplace issues in your preferred language at no cost. To talk to an interpreter, call **1-800-318-2596**.
- You also can appoint an authorized representative to help you.
  - Your representative can be a family member, friend, advocate, attorney, or someone else who will act for you. This can be done several ways, depending on the type of appeal you are filing. To get the forms you'll need to appoint a representative, visit **HealthCare.gov**.

Health Insurance Marketplace

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